STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	a. BUILDING 00			COMPLETED 12/29/2014	
		155530	B. WIN			12/29/	2014	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
SOUTH	SHORE HEALTH 8	REHABILITATION CENTER		353 TYI GARY,	IN 46402			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG F000000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F000000								
	This visit was fo	or the Investigation of	F00	0000				
	Complaint IN00							
	Companie in to a	, 1010111						
	Complaint IN00	0161017- Substantiated.						
	_	eficiencies related to the						
		cited at F-157, F-225, and						
	F-226.	,,						
	Survey date:							
	December 29, 2	.014						
	,							
	Facility number	: 000369						
	Provider numbe	er: 155530						
	AIM number: 1	00275190						
	Survey team:							
	Janet Adams, R	N-TC						
	Census bed type	e:						
	SNF/NF: 67							
	Total: 67							
	Census payor ty	pe:						
	Medicare: 7							
	Medicaid: 57							
	Other: 3							
	Total: 67							
	Sample: 3							
		ies reflect State findings nce with 410 IAC						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JETIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155530	B. WIN	G		12/29/	2014
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	-	353 TYL	.DDRESS, CITY, STATE, ZIP CODE .ER ST N 46402		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	16.2-3.1. Quality review c 29, 2014, by Jane	ompleted on December elyn Kulik, RN.					
F000157 SS=D	resident; consult we physician; and if ke legal representation member when the the resident which the potential for resident's physical status (i.e., a deteor psychosocial st	E/ROOM, ETC) nediately inform the with the resident's nown, notify the resident's re or an interested family re is an accident involving results in injury and has quiring physician nificant change in the l, mental, or psychosocial rioration in health, mental, atus in either life ions or clinical need to alter treatment a need to discontinue an extment due to adverse to commence a new form decision to transfer or dent from the facility as 12(a). Iso promptly notify the own, the resident's legal nterested family member					

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Event ID:

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155530	B. WIN			12/29	/2014	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	The facility must update the addrest the resident's leginterested family Based on record the facility fails was notified of swelling, rednes for 1 of 3 reside in the sample of the closed record reviewed on 12 resident's diagram of limited to, of pressure, and control of the sample of the sample of the sample of the sample of the closed record reviewed. The sample of the sample	record and periodically ess and phone number of gal representative or member. d review and interview, ed to ensure the Physician a new onset of leg ss and complaints of pain ents reviewed for injuries of 3. (Resident #C) de: ord for Resident #C was /29/14 at 9:30 a.m. The loses included, but were dementia, high blood occyx wounds. hysician orders were re was an order written on a.m. for X-rays of the fibula, foot, and ankle to ursing Progress Notes An entry made on a.m. indicated the sting quietly in bed and erbal and tactile stimuli. Indicated the resident plaints of pain and was in	F00	0157	The facility will notify physicial changes in condition of reside who are dependent or have injuries of unknown origin Resident #C's chart has been reviewed to ensure that notification occurred Follow was completed No new issue noted The 24-hour reports habeen reviewed for the past 30 days to identify any other changes in condition or injurie unknown origin for dependent residents. No new issues identified Nurses will be in-serviced on identifying issue of unknown origin, ensuring the 24-hour report is updated that incident reports are completed, with investigations DON or designee will monitor 24-hour reports and incident reports at least 3 times a wee ensure compliance. Results of audits will be reported to QA months or until problem is considered resolved. Problem be considered resolved if no it issues are noted after 3 mont of auditing. Request Paper Compliance.	n of ents up es ave) es of t es nat and s.	01/20/2015	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	E CONSTRUCTION	(-	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLETED
		155530	B. WING			12/29/2014
NAME OF F	PROVIDER OR SUPPLIEF	3	STRE	ET ADDRESS, CITY, STATE, 2	ZIP CODE	
				TYLER ST		
SOUTH	SHORE HEALTH &	REHABILITATION CENTER	GAR	Y, IN 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO	THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC	CY)	DATE
	_	entry indicated the				
		eep in the easy chair and				
		ain in the right leg.				
	_	nkle swelling were noted				
	· ·	narcotic pain medication)				
	was administere	d. The Physician was				
		eturn call and staff would				
	continue to mon	itor and render total care				
	for the resident.					
	The next entry w	vas made on 12/7/14 at				
	5:30 a.m. This e	ntry indicated the				
	resident complai	ned of foot pain and her				
	_	kle were swollen. The				
	_	ol # 3 (a narcotic pain				
	1	given and staff would				
	· · · · · · · · · · · · · · · · · · ·	itor the resident. There				
		ntation of the Physician				
		f the continued leg				
	redness, swelling	•				
	redicess, swering	s, and pam.				
	The next entry y	vas made on 12/7/14 at				
		entry indicated the				
		ce was called to obtain				
	1 0,	resident's foot, ankle, and				
	<u>-</u>					
	fight tibula [SiC] and fibula (leg bones).				
	Whom internal	ed on 12/29/14 at 9:55				
		or of Nursing indicated				
		first complained of pain				
		00 p.m. and the Physician				
		lid not call back. The				
		ing indicated the next				
	entry was made	on 12/7/14 and there was				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155530	B. WIN			12/29/	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER		353 TYL GARY, I	IN 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		n of the Physician being					
		sident's continued					
	_	s, and pain of the right					
	obtained on 12/7	er for X-rays were					
		/14 at 6.00 a.iii.					
	The facility police	cy titled "Notification for					
		ent Condition or Status"					
	_	12/29/14 at 12:20 p.m.					
		te on the policy. The					
		ing provided the policy					
		e policy was current. The					
		facility staff were to					
		the Physician of changes					
		medical or mental					
		us. The Policy also					
	indicated staff w	-					
		ian or the on-call					
	Physician when	injuries of an unknown					
	source were disc	overed, a need to alter					
	the resident's me	dical treatment					
	significantly, or	a change in the resident's					
	physical/emotion	nal/ or mental status.					
	_	relates to Complaint					
	IN00161017.						
	3.1-5(a)(2)						
F000225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)					
SS=D	INVESTIGATE/RE						
	ALLEGATIONS/IN The facility must n	IDIVIDUALS ot employ individuals who					
	The lacinty mast n	ot omploy marriadalo wilo					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G 00	(X3) DATE COMPI	LETED
		155530	B. WING			/2014
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	35	REET ADDRESS, CITY, STATE, ZIP (33 TYLER ST ARY, IN 46402	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX PROVIDER'S PLAN OF CORFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETION DATE
IAU	have been found of neglecting, or missicourt of law; or had into the State nursiabuse, neglect, missappropriation of any knowledge it have against an emindicate unfitness or other facility staregistry or licensing. The facility must eviolations involving abuse, including in and misappropriate are reported immediate administrator of the officials in accordate through established the State survey at the State survey at the facility must have alleged violations investigated, and inpotential abuse with progress. The results of all in reported to the addesignated repression of the Scertification agency the incident, and in the state incident in the state incident	guilty of abusing, reating residents by a ve had a finding entered se aide registry concerning istreatment of residents or of their property; and report has of actions by a court of ployee, which would for service as a nurse aide iff to the State nurse aide g authorities. Insure that all alleged g mistreatment, neglect, or nijuries of unknown source ion of resident property ediately to the e facility and to other ance with State law and procedures (including to not certification agency). Insure that all alleged g mistreatment, neglect, or nijuries of unknown source ion of resident property ediately to the e facility and to other ance with State law and procedures (including to not certification agency). Insure that all alleged g mistreatment, neglect, or nijuries of unknown source ion of resident property ediately to the efacility and to other ance with State law are thoroughly must prevent further nile the investigations must be ministrator or his entative and to other ance with State law				DATE
			F00022	The facility will notify p changes in condition of who are dependent or injuries of unknown or Resident #C's chart ha	of residents have igin	01/20/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155530	B. WIN			12/29/2014
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			353 TY		
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER			IN 46402	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	investigated in a	timely manner for 1 of 3			reviewed to ensure that	
	residents review	ed for injuries in the			notification occurred Follow up	•
	sample of 3. (Re	sident #C).			was completed No new issues noted The 24-hour reports ha	
	``	,			been reviewed for the past 30	ve
	Findings include				days to identify any other	
	i mamgs merade	•			changes in condition or injuries	s of
	The closed recor	d for Resident #C was			unknown origin for dependent residents No new issues	
	reviewed on 12/2	29/14 at 9:30 a.m. The			identified Nurses will be	
		ses included, but were			in-serviced on identifying issue	es
	_	ementia, high blood			of unknown origin, ensuring th	
	pressure, and coo				the 24-hour report is updated a	and
	pressure, and cod	ccyx woulds.			that incident reports are	
	D : 0.1 11	1001001435			completed, with investigations	
		/09/2014 Minimum			DON or designee will monitor	
	Data Set quarterl	y assessment indicated			24-hour reports and incident reports at least 3 times a week	r to
	the resident's cog	gnitive patterns for			ensure compliance Results of	
	decision making	were severely impaired.			audits will be reported to QA for	
	The assessment a	also indicated the			months or until problem is	
	resident was den	endent on two or more			considered resolved Problem	will
	_	or bed mobility, transfers,			be considered resolved if no n	
		he assessment indicated			issues are noted after 3 month	IS I
					of auditing Request Paper	
		dependent on one staff			Compliance.	
		sing, eating, and personal				
		sessment also indicated				
		eted care daily and				
	displayed physic	al behaviors directed				
	towards others d	aily during the				
	assessment refer	ence period.				
		^				
	The 12/2014 Phy	vsician orders were				
	-	was an order written on				
		.m. for X-rays of the				
	•	ibula, foot, and ankle to				
	be completed.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI		
		155530	B. WIN				72014
NAME OF P	ROVIDER OR SUPPLIER			STREET A	.DDRESS, CITY, STATE, ZIP COI LER ST	DE	
SOUTHS	SHORE HEALTH &	REHABILITATION CENTER		GARY, I	N 46402		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	The 12/2014 Nurwere reviewed. 12/6/14 at 2:00 a resident was restresponded to ver The entry also in voiced no compliant of acute distress. The next entry with 5:00 p.m. This eresident was asless complained of particular paged with no recontinue to monifor the resident. The next entry with 5:30 a.m. This erresident complaint right foot and an scheduled Tylen medication) was continue to monifor the resident complaint right foot and an scheduled Tylen medication) was continue to monifor the resident complaint right foot and an scheduled Tylen medication was no document being notified of redness, swelling. The next entry with 8:00 a.m. This error with the resident complaint right foot and an scheduled Tylen medication.	rsing Progress Notes An entry made on .m. indicated the ing quietly in bed and bal and tactile stimuli. dicated the resident aints of pain and was in . ras made on 12/6/14 at entry indicated the eep in the easy chair and ain in the right leg. akle swelling were noted harcotic pain medication) d. The Physician was turn call and staff would attor and render total care ras made on 12/7/14 at attry indicated the ned of foot pain and her kle were swollen. The ol # 3 (a narcotic pain given and staff would attor the resident. There tation of the Physician The continued leg					
,							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155530	B. WIN	G		12/29/2014
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE	
SOUTH S	SHORE HEALTH &	REHABILITATION CENTER		353 TYL GARY, I	LER ST IN 46402	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
IAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	DATE
		resident's foot, ankle, and [7] and fibula (leg bones).				
	i rigiit tibula [SiC	J and fibula (leg bolles).				
	The next entry y	vas made on 12/7/14 at				
		entry indicated the				
	_	n in "terrible pain" in the				
		emities. The entry also				
	~	s had been performed at				
	1	he results had not come				
	in yet.	ne results had not come				
	y ev.					
	An entry made o	on 12/8/14 at 2:00 a.m.				
	1	of the X-rays to the right				
		kle showed arthritic				
	_	fractures at this time.				
	An entry made of	on 12/8/14 at 6:15 p.m.				
	indicated the Nu	irse called the hospital to				
	check the status	of the resident and the				
	hospital indicate	ed the resident had a hip				
	fracture was goi	ng to be admitted to the				
	hospital.					
	,	on 12/8/14 at 7:00 p.m.				
		sident was sent to the				
		ency Room 1:45 p.m. and				
	was admitted to	the hospital.				
	and a second	10/5/14				
		e 12/7/14 results of the				
		knee, tibia, fibula, ankle				
	1	was reviewed. The				
	_	ed there was some				
		and degenerative				
	arthritic changes	s with no definitive				

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PRINTED: 01/12/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
THIND I LIMIT	or conduction	155530		LDING		12/29/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	. =, = 0.	
NAME OF F	PROVIDER OR SUPPLIEF			353 TYL			
SOUTH	SHORE HEALTH &	REHABILITATION CENTER			IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		nt fracture or dislocation		TAG	,		DATE
		and femur. The report					
		e results of the right					
		a, and ankle revealed					
	mild soft tissue s						
	11111 u 501 v v155 u v	,					
	When interviewe	ed on 12/29/14 at 9:55					
	a.m., the Directo	or of Nursing indicated					
	the resident was	admitted to the hospital					
	on 12/8/14 with	a diagnosis of a right hip					
	fracture. The Dir	rector of Nursing					
	indicated the fac	ility called the hospital					
	and was told the	resident had a right hip					
		rector of Nursing					
		ident did not have a fall					
		or to the pain and					
	_	oot. The Director of					
		d she did not do an					
	_	the resident's right					
		g, redness, and pain on					
		7/14. The Director of					
	_	d after she was notified					
		n 12/8/14 she did talk to					
		f to verify the resident did					
	not have any fall	IS.					
	When interviewe	ed on 12/29/14 at 10:50					
		or of Nursing indicated					
	*	o incident report and she					
		ified of the swelling and					
		ent's right foot on					
	-	14. The Director of					
		ed when she spoke with					
	_	CNAs on Monday					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
THIE TEAT	or condition	155530		LDING		12/29/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	. =, = 0.	
NAME OF F	PROVIDER OR SUPPLIER			353 TYL			
SOUTH	SHORE HEALTH &	REHABILITATION CENTER			IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ed them if the resident		TAG	Dia lettike 1		DATE
		I they indicated she did					
	· ·	or of Nursing indicated					
		ired the assistance of two					
	_	or transfers. The Director					
		indicated the resident had					
		ing with staff with					
		e. The Director of					
		d she was not working					
	on 12/6/14 (Satu	•					
	1	as not informed of the					
		nset of leg pain, swelling					
	and redness until						
	When interviewe	ed on 12/29/14 at 12:15					
	p.m., the Directo	or of Nursing indicated					
	_	ding bruises, skin tears or					
	_	could not be explained					
	were to be invest	tigated.					
	When interviewe	ed on 12/29/14 at 11:20					
	a.m., the Social	Service Director					
	indicated the res	ident did have behaviors					
	and would be ph	ysically aggressive with					
	staff when they	were providing care for					
	the resident.						
		ed on 12/29/14 at 12:40					
		Administrator indicated					
	_	known origin were to be					
	investigated. Th						
		cility should have					
		resident's pain, swelling,					
	and redness to the	ne leg earlier when first					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155530	A. BUILDING	00	COMPLETED
		100000	B. WING		12/29/2014
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE LER ST	
SOUTH	SHORE HEALTH 8	REHABILITATION CENTER		IN 46402	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE	
F000226 SS=D	noted by staff sidependent on stable history of being. This Federal tag IN00161017. 3.1-28(c) 483.13(c) DEVELOP/IMPLNETC POLICIES The facility must written policies armistreatment, nearesidents and misproperty. Based on record the facility faile Policy related to of unknown or or reviewed for inj (Resident #C) Findings include The closed recordinate in the closed recordinate	rd for Resident #C was 29/14 at 9:30 a.m. The oses included, but were ementia, high blood	F000226		p s ve s of es aat and

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIII	LDING	00	COMPLETED		
155530		B. WIN			12/29/2014			
			D. WII		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
SOUTH SHORE HEALTH & REHABILITATION CENTER				353 TYLER ST GARY, IN 46402				
					114 40402			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	+-	TAG	,	DAT	Е	
	the resident's cognitive patterns for				24-hour reports and incident	to		
	decision making	were severely impaired.			reports at least 3 times a week ensure compliance Results of			
	The assessment also indicated the				audits will be reported to QA			
	resident was dep	endent on two or more			months or until problem is			
	_	or bed mobility, transfers,			considered resolved Problem	will		
		The assessment indicated			be considered resolved if no n			
		dependent on one staff			issues are noted after 3 month	s		
		sing, eating, and personal			of auditing Request Paper			
		C. C. 1			Compliance.			
	hygiene. The assessment also indicated the resident rejected care daily and							
		eal behaviors directed						
	towards others d	aily during the						
	assessment refer	ence period.						
	The 12/2014 Phy	ysician orders were						
		e was an order written on						
		a.m. for X-rays of the						
	resident's tibia, fibula, foot, and ankle to be completed.							
	The 12/2014 Nu	rsing Progress Notes						
	were reviewed.	An entry made on						
	12/6/14 at 2:00 a	a.m. indicated the						
		ting quietly in bed and						
		bal and tactile stimuli.						
	-	ndicated the resident						
	_							
	_	laints of pain and was in						
	no acute distress	J.						
	The next entry w	vas made on 12/6/14 at						
	5:00 p.m. This e	entry indicated the						
	resident was asle	eep in the easy chair and						
		ain in the right leg.						
		nkle swelling were noted						
	Kigiit 100t and al	iikie sweiiiiig weie iioled						

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i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPLETED		
		155530	B. WIN			12/29/2014	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
SOUTH SHORE HEALTH & REHABILITATION CENTER				353 TYL GARY,	LER ST IN 46402		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT			
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	and Vicodan (a narcotic pain medication)						
		d. The Physician was					
		turn call and staff would					
		itor and render total care					
	for the resident.						
	The next entry w	vas made on 12/7/14 at					
		ntry indicated the					
		ned of foot pain and her					
	_	kle were swollen. The					
	scheduled Tylenol # 3 (a narcotic pain						
	medication) was given and staff would						
	continue to monitor the resident. There						
		tation of the Physician					
	being notified of the continued leg						
	redness, swelling	•					
	The next entry w	vas made on 12/7/14 at					
	8:00 a.m. This e	entry indicated the					
	Radiology Service	ce was called to obtain					
	an X-ray of the r	esident's foot, ankle, and					
	right tibula [SIC]	and fibula (leg bones).					
	The next entry was made on 12/7/14 at 5:05 p.m. This entry indicated the resident had been in "terrible pain" in the right lower extremities. The entry also indicated X-rays had been performed at						
	11:20 a.m. and th	he results had not come					
	in yet.						
	An ontwo mode -	n 12/9/14 at 2:00 a m					
		n 12/8/14 at 2:00 a.m.					
		of the X-rays to the right kle showed arthritic					
	i tool, ick, allu alli	NIC SHOWER ALUHITUC	1		İ	I	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00		SURVEY LETED 1/2014	
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	changes and no findicated the Nu check the status hospital indicate fracture was goin hospital. An entry made of indicated the result hospital indicated the result hospital indicated the result hospital Emergency was admitted to the right hip, femur, and foot X-rays findings indicated demineralization arthritic changes evidence of recession of the right hip and also indicated the knee, tibia, fibuli mild soft tissue so the resident was on 12/8/14 with fracture. The Director indicated the fact and were told the status indicated the st	fractures at this time. In 12/8/14 at 6:15 p.m. In rese called the hospital to of the resident and the did the resident had a hip ing to be admitted to the including to the admitted to the incy Room 1:45 p.m. and the hospital. In 12/8/14 results of the knee, tibia, fibula, ankle was reviewed. The did there was some and degenerative with no definitive interacture or dislocation and femur. The report is results of the right and ankle revealed swelling. In 12/8/14 at 7:00 p.m. identify the hospital and ankle revealed swelling.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPL		
		155530	B. WIN			12/29/	2014
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
SOUTH SHORE HEALTH & REHABILITATION CENTER				353 TYL	LER ST IN 46402		
					111 40402		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		ident did not have a fall					
		or to the pain and					
	J 1	oot. The Director of					
	_	d she did not do an					
	_	the resident's right					
	_	g, redness, and pain on					
		/14. The Director of					
		d after she was notified					
	_	1 12/8/14 she did talk to					
		to verify the resident did					
	not have any fall						
		~ .					
	When interviewe	ed on 12/29/14 at 10:50					
		r of Nursing indicated					
		o incident report and she					
		ified of the swelling and					
		ent's right foot on					
	_	14. The Director of					
	Nursing indicate	d when she spoke with					
	_	CNAs on Monday					
		d them if the resident					
	had any falls and	I they indicated she did					
		or of Nursing indicated					
		ired the assistance of two					
	•	or transfers. The Director					
	of Nursing also i	ndicated the resident had					
		ing with staff with					
		e. The Director of					
	Nursing indicate	d she was not working					
	on 12/6/14 (Satu	•					
	· ·	is not informed of the					
		nset of leg pain, swelling					
	and redness until						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530		A. BUI	LDING	00	COMPL		
		155530	B. WIN			12/29/	2014
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
SOUTH SHORE HEALTH & REHABILITATION CENTER				353 TYL	IN 46402		
					111 10102	1	(V.5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	When interviewe	ed on 12/29/14 at 12:15					
		or of Nursing indicated					
		ding bruises, skin tears or					
	1	could not be explained					
	were to be inves	tigated.					
	When interviewe	ed on 12/29/14 at 11:20					
	a.m., the Social						
		ident did have behaviors					
	1	ysically aggressive with					
	1	were providing care for					
	the resident.						
		1 10/00/41 110					
		ed on 12/29/14 at 12:40					
	1 * '	Administrator indicated					
	1	known origin were to be					
	investigated. Th						
		cility should have resident's pain, swelling,					
	1	ne leg earlier when first					
		nce the resident was					
	_	off for care and had a					
		aggressive with care.					
	motory or being	4001000110 Williamo.					
	The facility police	cy titled "Abuse/Neglect					
		vas reviewed on 12/29/14					
		e policy had a revised					
	_	008. The Director of					
	Nursing provide						
		icy was current. The					
	_	all reports and/or					
	allegations of ab	use, neglect, and injuries					
	of unknown sour	rce were to be promptly					
	and thoroughly i	nvestigated by facility					

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PRINTED: 01/12/2015 FORM APPROVED OMB NO. 0938-0391

-	NOT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI. OF CORRECTION IDENTIFICATION NUMBER: 155530	A. B)	MULTIPLE CO UILDING VING	NSTRUCTION 00	(X3) DATE COMPI 12/29	LETED
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER			353 TYL	DDRESS, CITY, STATE, ZIP CODE LER ST N 46402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	management. The policy indicated the investigations should include interviews with staff members (on all shifts) who had contact with the resident during the alleged incident.					
	This Federal tag relates to Complaint IN00161017. 3.1-28(a)					

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